KanCare Meaningful Measures Collaborative

December 2, 2021

Recommendations to Support KanCare Procurement and Waiver Processes

Based on the feedback in the KanCare Meaningful Measures Collaborative (KMMC) full member meeting in June 2021, the Executive Committee recommended that KMMC leverage its previous recommendations to support the State of Kansas preparation of the upcoming KanCare procurement and waiver processes. Criteria to be considered when weighing the potential of each recommendation in this process includes:

- Relevance to the upcoming KanCare procurement and waiver processes.
- Components or approaches to a recommendation could be incorporated into future KanCare contracts or program evaluation plans.

Previous recommendations included seven priority areas: (1) Pregnancy Outcomes, (2) Care Coordination, (3) Network Adequacy and (4) Social Determinants of Health (SDOH) from the full recommendation report in 2020, (5) Telehealth, (6) Behavioral Health and (7) Quality Assurance from the full recommendation report 2021. Since there is an ongoing effort related to SDOH, this summary focused on the remaining six priority areas.

The task group leader for each priority area reviewed previous recommendations and identified areas that meet the criteria described above. Results were presented and discussed in the KMMC full member meeting in September 2021. This document includes the summary from the task groups and the discussion in the KMMC quarterly meeting (September 2021) for each priority area.

Pregnancy Outcomes

Task Group Summary

- Summary report or dashboard: Develop a summary report or a dashboard to monitor measures on pregnancy including health care process and clinical outcomes.
- Trend and subgroup analysis: Conduct analysis to monitor changes over time and identify subpopulation and geographic areas at risk of poor outcomes for continuous improvement.

The existing measures for pregnancy outcomes are timeliness of prenatal care and postpartum care. These are currently collected from each managed care organization (MCO) as the existing HEDIS measures. This task group recommends adding new measures: birth weight, gestational age, and infant mortality information. Another recommendation was to identify if disparities or inequities exist in the measures and explore the use of Pregnancy Risk Assessment Monitoring System (PRAMS) data. With these measures, a summary report or a dashboard can be developed to monitor measures on the pregnancy including health care process and clinical outcomes, and then conduct trend and subgroup analysis to identify subpopulations or geographic areas that are currently have poor outcomes and need continuous improvement.

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Anna Purcell summarized the recommendations for pregnancy outcomes. The existing measures currently collected by MCOs include HEDIS measures on timeliness of prenatal care and postpartum care. The task group recommended collecting several new measures, e.g., birth weight, gestational age and infant mortality, identifying if disparities exist in these measures and exploring the use of the PRAMS data.

For the upcoming procurement process, the recommendation is to include a summary report or a dashboard to monitor measures on the pregnancy process and outcomes, and then conduct trend and subgroup analysis to identify subpopulations or geographic areas with poor outcomes for continuous improvement. Please see the *Task Group Summary* above for details.

KMMC members discussed the timeliness of data to inform the program, health plans and providers to manage potential risks. Currently, the information would be delayed due to the lag in claims data (a provider has 180 days to submit a claim). Also, a portion of maternity claims in Kansas are globally billed, meaning that all services are bundled together and not submitted until the baby is delivered. Additionally, HEDIS measures must be fully audited before MCOs release that information.

Therefore, an alternate approach could be considered if we want a more timely, actionable dashboard with the known caveats. A longer-term approach could leverage the data for predictive modeling to help identify factors associated with increased risk for poor outcomes. If providers can receive the information in advance, it might provide the opportunity to mitigate risk.

Care Coordination

Task Group Summary

- Serious emotional disturbance (SED) waiver: Consider requiring an SED Waiver-specific survey be completed by MCOs and explore the potential for the Child ECHO Behavioral Health survey to include a supplemental sample of children and youth receiving SED waiver services.
- HCBS CAHPS: Consider requiring the MCOs to complete the HCBS CAHPS survey (one MCO already does this), stratified by waiver and including questions for both Targeted Case Management and MCO Care Coordination.
- HCBS CAHPS: Increase sample size for subgroup analysis by alternating years in which additional sampling is conducted for specific subgroups and to use the hybrid approach, with a combination of in-person and phone surveys.
- National Core Indicator: Consider increasing resources for the National Core Indicator TM (NCI) and NCI-Aging and Disabilities TM (NCI-AD) surveys by eliminating the HCBS CAHPS survey which has substantial overlap and fewer domains. This approach will help pool resources together.

General Care Coordination by Providers:

Care Coordination 1. KanCare could consider opportunities to develop measures that capture perception of services particularly of members on the serious emotional disturbance (SED) waiver.

Potential approaches:

- Consider requiring an SED Waiver-specific survey be completed by MCOs; this could involve development of a survey questionnaire all MCOs would use to allow for comparisons and potential aggregation. Aggregation and comparisons could be completed through a coordinated MCO effort, similar to the SUD survey. Alternatively, the comparisons and aggregation could be added to the EQRO contract, similar to what occurs with the CAHPS Health Plan surveys.
- Explore the potential for the Child ECHO Behavioral Health survey (currently subcontracted to be conducted by an NCQA certified survey vendor through the EQRO contract) to include a supplemental sample of children and youth receiving SED Waiver services selected from the records not already selected for the general child ECHO survey. Responses of all children/youth from the general child survey that receive SED Waiver services would be combined with responses from the supplemental sample. This could parallel the process used for the CAHPS children with chronic conditions module.

Care Coordination 2. KanCare could consider increasing the number of HCBS consumer surveys conducted for each waiver to allow for sub-group analysis in regard to survey questions about providers.

Care Coordination 3. KanCare could consider reviewing the reported information from the first data year of HCBS CAHPS Surveys to make recommendations on survey administration strategies, sampling needs or inclusion of additional questions.

Potential approaches:

- Consider requiring the MCOs to complete the HCBS CAHPS survey (one MCO already does), stratified by waiver and including questions for both Targeted Case Management and MCO Care Coordination. The EQRO contract could include aggregation of the MCOs' results by waiver type, and an MCO comparison of the overall results (not by waiver, since there wouldn't be enough responses by MCOs to compare).
- Other potential solutions to increasing responses for a statewide HCBS CAHPS survey could be to alternate years in which additional sampling is conducted for specific subgroups and to use the hybrid approach, with a combination of in-person and phone surveys, as seen in some states. KanCare could consider opportunities to increase the number of I/DD waiver members participating in the HCBS CAHPS Survey to capture the experiences of those receiving targeted case management (TCM).
- Consider increasing resources for the National Core Indicator™ (NCI) and NCI-Aging and Disabilities ™ (NCI-AD) surveys by eliminating the HCBS CAHPS survey which has substantial overlap and fewer domains. By combining funding from the two types of surveys, potentially enough members would be surveyed to allow for the waiver stratification. The NCI surveys adults with intellectual or developmental disabilities (I/DD) and the NCI-AD surveys adults who receive supports because of a physical disability and/or an age-related disability. Consider adding supplemental questions (such as in the HCBS CAHPS survey) regarding Targeted Case Management versus MCO Care Coordination for the NCI survey.

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Lynne Valdivia presented the priority topic of Care Coordination. Measures on care coordination tend to focus on the data around consumer satisfaction, i.e., consumer feedback around care management and needs. However, KMMC stakeholders would like to have more specific data for waiver participants.

Approaches were suggested for collecting data from serious emotional disturbance (SED) waiver participants, members with targeted case management and other HCBS waivers.

Suggestions included ways to increase the sample size for each type of waiver participant, considering alternate surveys and review overlaps between surveys to pool resources together. Please see *Task Group Summary* above for details.

KMMC members discussed how recommendations could be included in the KanCare and waiver process. Some of these measures could be for KanCare overall and others could be related to potential RFP and eventual contracts. For example, if the state wants to require each MCO to conduct the HCBS CAHPS, it could be included in the RFP.

Another suggestion discussed was that MCOs should report the number of children who receive care coordination services and have been offered the SED waiver. MCOs contributing their data to a universal platform was also discussed.

Network Adequacy

Task Group Summary

- Network Adequacy Reporting: Continue to strengthen the standardized and systemized reporting from MCOs.
- Monitoring process: Formulate and utilize program monitoring data to help identify areas for continuous improvement.
- HCBS waivers: Conduct analysis to measure the adequacy of waiver service provider availability for waiver participants.
- Consumer Information: Improve information sharing in responding to common questions from consumers and informing consumers regarding the process when issues related to provider availability arise.

Members regularly have questions about where to find information and how measures on the network advocacy website are calculated. The KanCare Network Adequacy website has been changed a couple times and provides a rich set of information. The information provides a snapshot on a quarterly basis. MCOs provide the data to KanCare for further processing to generate the information for the public. A recommendation is for KanCare to continue strengthening consistent reporting across MCOs.

Additional measures for HCBS providers could be considered in the procurement process. Currently, only two types of HCBS providers (adult day care and day supports) are included in the report. Expanding the list of measures for the reporting would be very helpful for monitoring the workforce shortage.

Although evaluation or monitoring efforts have been put in place, the information has not been available to the public. If data can be collected systematically for these programs, e.g., secret shoppers, analyses can be conducted to help identify certain geographic areas or certain types of populations that might need additional support.

Members are looking for real-time information when they need care. Even though the network adequacy shows that providers are available in the geographic area, they might not accept new patients, the wait time for an open appointment is long, or members might need to travel long distance. In these situations, members have had a difficult time finding information to communicate with MCOs and get their needs met. Improving the information sharing to guide people through the process to have their needs met is another recommendation for network adequacy.

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Wen-Chieh Lin summarized the recommendations on Network Adequacy. The KanCare network adequacy website has been changed to provide more information. MCOs provide the data to KanCare for further processing for the website.

The recommendations for the upcoming procurement process include continuing and strengthening consistent reporting across MCOs; making data collection for monitoring efforts, e.g., secret shoppers, more systematic for analysis; expanding the number of measures on HCBS providers; and improving information sharing with members regarding what they can do when they encounter issues with provider availability. Please see the Task Group Summary above for details.

KMMC members suggested that in the upcoming procurement process the state seek more innovative approaches to solving these issues and ask bidders how they will boost network adequacy across the state.

Telehealth

Task Group Summary

- Develop measures to track the telehealth concepts outlined in Figure 2 (page 8 of the recommendation report in 2021), to understand factors influencing consumer access and provider ability to administer telehealth services in KanCare.
- In addition to measuring access of telehealth services, KanCare could adopt measures from the other three domains outlined by the National Quality Forum in its telehealth framework, including: a) Financial Impact/Cost b) Experience and c) Effectiveness.
- Develop a way to track whether telehealth services are provided via video or audio-only modalities, such as by adding a modifier to claims to indicate how the service was delivered. Audio-only modalities should also continue in order to make telehealth services accessible to those who cannot access video-only services.
- Only once the data collection is provided through the program, can analysis of telehealth's impact on access, patient outcomes, etc. be assessed.

The recommendations developed for the 2021 report had the KanCare procurement process in mind, since this area is one that is not currently monitored or incentivized in the current program. As it relates to the recommendations to be discussed, Recommendations 1, 2 and 4 are included:

Telehealth 1: Develop measures to track the telehealth concepts outlined in Figure 2 (page 8 of the recommendation report in 2021), to understand factors influencing consumer access and provider ability to administer telehealth services in KanCare.

Telehealth 2: In addition to measuring access of telehealth services, KanCare could adopt measures from the other three domains outlined by the National Quality Forum in its telehealth framework, including:

a) Financial Impact/Cost
b) Experience
c) Effectiveness

Telehealth 4: Develop a way to track whether telehealth services are provided via video or audio-only modalities, such as by adding a modifier to claims to indicate how the service was delivered. Audio-only modalities should also continue to make telehealth services accessible to those who cannot access video-only services.

Only once the data collection is provided through the program, can analysis of telehealth's

impact on access, patient outcomes, etc., be assessed.

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Sarah Irsik-Good noted that the Telehealth task group developed a set of recommendations for how to build a data set to start answering questions. The group outlined those concepts in a specific table as shown on page 8 of the recommendation report in 2021.

In addition to measuring access, a recommendation was discussed to adopt measures from the other three domains identified by the National Quality Forum including financial impact and cost, the experience of those receiving and providing telehealth services, and effectiveness of clinical and operational systems.

Another recommendation was to add a modifier for claims submissions or develop a new reporting mechanism to understand how telehealth services were delivered, i.e., face to face, over a video connection, or audio only, to help assess the efficacy of those services.

The task group collectively decided that only once we are able to collect data for the KanCare program, whether data collection was written into MCO contracts or built into the overall evaluation of the program, would we really be able to analyze and study the impact of telehealth services on access and patient outcomes.

KMMC members discussed the increased use of telehealth, service modes (i.e., video or audio-only), and types of technology barriers. In-depth studies were suggested to better understand access issues from the patient perspective when telehealth services are provided.

Behavioral Health

Task Group Summary

- Access to telehealth: Developing a robust telehealth option for behavioral health services in KanCare with reasonable reimbursement attached will be key to the ongoing success of these services, which are often preferred by individuals receiving behavioral health treatment.
- Medicaid/CHIP Behavioral Health Core Set: Improve key quality measures including:
    - Adherence to antipsychotic medications for individuals with schizophrenia for members age 19 to 64
    - Initiation and engagement of alcohol and other drug abuse or dependence for members age 18 and older
- Mental health parity: Incorporate mental health parity expectations and reporting in the KanCare contracts.

Kansas has the opportunity to incorporate greater expectations of their KanCare contracts in the next round of requests. Our group is hopeful that the recommendations relating to behavioral health will rank high for quality improvement measures and the collection of meaningful data.

For individuals with mental health or substance use disorder needs, the recommendations for all KanCare participants are very important:

- Care Coordination
- Network Adequacy
- Social Determinants of Health

To this end, seeking managed care organizations with the capacity to meet quality measures in these areas is just as important if not more. This requires more than passive reporting of the current situation, but an action plan to improve these measures.

For Behavioral Health specifically, the recommendations include:

Behavioral Health 1: Develop a summary report of meaningful measures for behavioral health that include information on the prevalence of behavioral health disorders (Figure 3, page 12) and access to services (Figure 4, page 12) in the recommendation report in 2021.

a) Prevalence of behavioral health disorders: proportion of KanCare members with mental health disorders, SUDs or co-occurring diagnoses of varying levels of severity.

b) Access to services: KanCare member ability to access services, with a focus on receiving services in a timely manner.

Behavioral Health 2: Explore the ability to incorporate additional metrics related to the effectiveness of prevention efforts in the state, including a focus on children in the child welfare system or at-risk of entering the child welfare system.

Behavioral Health 3: Identify and report additional information on the extensiveness of homelessness within the behavioral health population in KanCare, expanding beyond information currently reported for those with serious and persistent mental illness (SPMI). Consistent definitions of homelessness should be used across populations.

Access to Telehealth

One of the most promising developments in access to care is telehealth. Providers report that the opening of telehealth opportunities, along with parity pay, has increased access for many individuals whether they lack transportation, need to care for children, or simply struggle with other barriers to making appointments.

Requiring a robust telehealth option for behavioral health services in KanCare with reasonable reimbursement attached will be key to the ongoing success of these services, which are often preferred by individuals receiving behavioral health treatment.

Quality of Care

One way CMS measures quality of care in Medicaid and CHIP programs is through two core sets of measures, one for children and one for adults. Each quality measure is accompanied by a gauge that allows you to view Kansas's performance in comparison to other states reporting the measure. In federal fiscal year (FFY) 2019, Kansas voluntarily reported 17 of 21 frequently reported health care quality measures in the CMS Medicaid/CHIP Child Core Set. Kansas voluntarily reported 18 of 24 frequently reported health care quality measures in the CMS Medicaid Adult Core Set.

Within the reported measures, Kansas mostly falls within the range of the bottom quartile, the median, and the top quartile of the 37 reporting states. In a few categories, Kansas exceeds these measures. Unfortunately, there are three adult quality measures where Kansas falls below the bottom quartile:

- Adherence to Antipsychotic Medications for Individuals with Schizophrenia: Ages 19 to 64
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment:

Age 18 and Older

- Breast Cancer Screening: Ages 50 to 74

(Source: https://www.medicaid.gov/state-overviews/stateprofile.html?state=kansas)

Components for the KanCare procurement process

One obvious area for change is incorporating these as quality improvement measures. Specifically, bidders should be asked two important questions:

1. How would the bidder be able to contribute to the meaningful data collection and publication?
2. How has the bidder improved the outcomes proposed by this group and what practices have they implemented as an entity (not put upon their providers) to improve the six areas within these recommendations?

Finally, it is time to know what the state needs to prepare KanCare for the Federal reporting that Kansas has not been requiring of the MCOs. CMS says that they will have to complete the Medicaid managed care report in accordance with 42 CFR § 438.66.

CMS says that they will have to complete and submit the Medicaid managed care report directly to CMS. States will have to explain how they are going to accomplish this reporting in waiver renewals. https://www.medicaid.gov/federal-policy-guidance/downloads/cib06282021.pdf

Mental Health Parity – a quick note

States are quickly changing their expectations for compliance with Federal Mental Health Parity laws and the courts are hastening this reform. Kansas should incorporate mental health parity expectations and reporting in the KanCare contracts.

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Amy Campbell presented recommendations for behavioral health. The task group came up three sets of recommendations as shown on page 11 of the Recommendation Report 2021. The recommendations for the upcoming KanCare procurement process include a robust telehealth option for behavioral health services in KanCare with reasonable reimbursement to ensure the ongoing success of these services; reporting key quality measures on the adherence to antipsychotic medications and the initiation and engagement of substance use disorder treatment; and incorporate mental health parity expectations and reporting.

Specifically, Amy said bidders should be asked two important questions:

1. How would the bidder be able to contribute to meaningful data collection and publication?
2. How has the bidder improved the outcomes proposed by this group and what practices have they implemented as an entity (not put upon their provider networks) to improve the six areas of recommendations?

Quality Assurance

Task Group Summary

- Tracking whether HCBS consumers are receiving the services they need and are qualified to receive, and developing benchmarks and more robust systems of accountability.
- HCBS Service Plan Performance Measures: Develop benchmark goals and incentives, as well as additional measures.
- Consumer interview and record review methodologies: Ensure validation and Representativeness.
- HCBS CAHPS: Increase sample size for subgroup analysis.
- Direct care workers: Measure their availability for adequate workforce and access.
- AuthentiCare: Explore the potential for measuring authorized and fulfilled hours for direct care.
- HCBS person-centered care: Ensure adequate hours are authorized and fulfilled.

Carrie Wendell-Hummel (KU Center for Research on Aging and Disability Options) was not able to stay for the entire KMMC meeting. She submitted a document below to summarize the recommendations on quality assurance. Carrie revisited these recommendations in light of the upcoming KanCare procurement process. Note, she did not have an opportunity to discuss these recommendations with other members of the task group, and so this is just a starting point for KMMC consideration.

Overview of prior recommendations:

- Based on stakeholder input, the research question we identified was, "Are Home and Community Based Services (HCBS) populations receiving the level of services needed?" This includes all 7 waivers in Kansas.
- We identified several measures that help answer this question, including the HCBS CAHPS (Client Assessment of Healthcare Providers and Systems) survey, NCI-AD (National Core Indicators- Aging and Disability) survey, record review, and customer interviews. We made recommendations around expanding CAHPS and NCI-AD, as these survey measures were not available across all waivers and sample sizes are too small to support comparisons or subgroup analysis.
- We also recommended new measures be developed, including the need to measure the availability of direct care workers and exploring the potential for using other data sources, such as APS/CPS data (adult and child protective services), MCO member surveys, and AuthentiCare data.

This is a key quality measure, as concerns about waiver consumers not receiving all authorized services have only grown during the pandemic, which is largely driven by direct support workforce shortages in which consumers struggle to find and retain good personal care attendants. Based on both reports from the field and ongoing research by Carrrie's team at KU, it's clear that these workforce shortages have also only grown during the pandemic. However, as these are longstanding concerns, we cannot expect these issues to go away after the pandemic. Unmet care needs place HCBS consumers at great risk of institutionalization, hospitalization, and other adverse health outcomes. Thus, with the importance of this quality measure in mind during the KanCare procurement process, the following next steps are recommended:

1. Program administrators need to know more about how the related performance measures operate in the current KanCare contracts. KMMC previously identified 6 performance measures related to this question. What are the benchmark goals for each measure and what are the incentives for reaching these benchmarks? This would provide a useful starting point to consider whether these incentives should be updated, including whether any of the additional identified measures should be included as performance measures.
2. Take a deeper dive into consumer interview and record review methodologies to ensure these are valid and representative measures, especially considering the predominance of these data sources in current performance measures.
3. We previously discussed the need for larger CAHPS sample sizes to allow for subgroup analysis. Thinking about sample size needs in light of MCO procurement and accountability, a larger sample size is also needed to support comparisons across geographic regions, as this may impact access to services more than waiver type.
4. We noted a need to measure the availability of direct care workers. This remains an important and key recommendation in light of KanCare procurement, and thus needs further refinement. There may be overlap or lessons from KMMC recommendations on provider network adequacy that could be carried over to this recommendation.
5. We noted the potential of using AuthentiCare as a source of meaningful data. AuthentiCare supports payroll for consumers and direct support workers, so it is a rich source of data on the number of direct care hours authorized and the number filled. Previously, we did not take a deep dive into AuthentiCare as a potential data source, but this would be a timely moment to explore this further and make more specific recommendations.
6. Finally, we never addressed whether HCBS person-centered care plans are

authorizing an appropriate number of hours in the first place, and thus, we should revisit data sources with this question in mind. There are growing concerns among advocates about consumers who are only awarded one hour of care per week, even though they meet the institutional level of care standard. Further, in exploring how the MCO contracts could better ensure that care hours are filled, we need to make sure there's not a perverse incentive to increase the proportion of filled hours by reducing the number of authorized hours.

Combined, the above-mentioned data, if collected in a valid and representative way, can track whether HCBS consumers are receiving the services they need and are qualified to receive, and thus also be used to develop benchmarks and more robust systems of accountability in MCO contract requirements. As thinking about our prior recommendations in light of KanCare procurement brings forth new questions and potentially shifts the priority of some of our recommendations, it is recommended that the QA taskforce reconvene to consider these and other KMMC member recommendations.